



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

Memorial Compounding RX

**Respondent Name**

American Zurich Insurance Co

**MFDR Tracking Number**

M4-18-0868-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

November 30, 2017

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "The carrier has received the attached bill and has not processed according to Texas Labor Code 408.027."

**Amount in Dispute:** \$555.68

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The Carrier submitted the compound cream the subject of this dispute for medical necessity review by a utilization review agent. The URA has determined the prescribed compound cream is not consistent with and exceeds the recommendations of the ODG, and is not medically necessary."

**Response Submitted by:** Flahive, Ogden & Latson

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 13, 2017	Pharmacy Services - Compounds	\$555.68	\$555.68

### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.502 sets out the procedures for pharmaceutical benefits.
3. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
4. 28 Texas Administrative Code §134.530 sets out the closed formulary requirements for claims not subject to certified networks.
5. No explanation of benefits were submitted by either party.

## Issues

1. Did the respondent raise a new defense pursuant to 28 Texas Administrative Code §133.307?
2. Is Memorial Compounding Pharmacy entitled to reimbursement for the compound in question?

## Findings

1. In its position statement, Flahive, Ogden and Latson on behalf of American Zurich Insurance Co “The ...URA has determined the prescribed compound cream is not consistent with and exceeds the recommendations of the ODG, and is not medically necessary.”

28 Texas Administrative Code §133.307(d)(2)(F) states, in relevant part, “The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.”

Review of the submitted documentation finds that American Zurich Insurance Co failed to present a medical necessity denial to Memorial Compounding Pharmacy in accordance with 28 Texas Administrative Code §133.240 prior to the date the request for medical fee dispute resolution (MFDR) was filed. The URA review is dated December 1, 2017, the date of service in dispute is July 13, 2017. The request for Medical Fee Dispute Resolution was November 30, 2017. The division concludes that this defense presented in Respondent’s position statement shall not be considered for review because this assertion constitutes a new defense pursuant to 28 Texas Administrative Code §133.307(d)(2)(F).

2. 28 Texas Administrative Code §134.503 applies to the compounds in dispute and states, in pertinent part:
  - (c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:
    - (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:
      - (A) Generic drugs:  $((\text{AWP per unit}) \times (\text{number of units}) \times 1.25) + \$4.00$  dispensing fee per prescription = reimbursement amount;
      - (B) Brand name drugs:  $((\text{AWP per unit}) \times (\text{number of units}) \times 1.09) + \$4.00$  dispensing fee per prescription = reimbursement amount;
      - (C) When compounding, a single compounding fee of \$15 per prescription shall be added to the calculated total for either paragraph (1)(A) or (B) of this subsection; or
    - (2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:
      - (A) health care provider; or
      - (B) pharmacy processing agent only if the health care provider has not previously billed the insurance carrier for the prescription drug and the pharmacy processing agent is billing on behalf of the health care provider.

The compound in dispute was billed by listing each drug included in the compound and calculating the charge for each drug separately as required by 28 Texas Administrative Code §134.502(d)(2). Each ingredient is listed below with its corresponding reimbursement amount as applicable.

Ingredient	NDC & Type	Price/ Unit	Total Units	AWP Formula §134.503(c)(1)	Billed Amt §134.503 (c)(2)	Lesser of (c)(1) and (c)(2)
Baclofen	38779038809 Generic	\$35.63	5.4	\$226.69	\$190.78	\$190.78
Amantadine HCL	38779041105 Generic	\$24.225	3	\$94.84	\$72.69	\$72.69
Gabapentin USP	38779246109 Generic	\$59.85	3.6	\$303.25	\$204.66	\$204.66
Bupivacaine HCL	38779052405 Generic	\$45.60	1.2	\$61.00	\$54.72	\$54.72
Amitriptyline	38779018904 Generic	\$18.24	1.8	\$49.60	\$32.83	\$32.83
					Total	\$555.68

The total reimbursement is \$555.68. This amount is recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$555.68.

### ***ORDER***

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor \$555.68, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

### **Authorized Signature**

Signature	Medical Fee Dispute Resolution Officer	December 29, 2017 Date
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### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim. The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**